Washington State Health Care Authority
Public Employees Benefits Board

2012 Employee Enrollment/Change

- **List eligible family members you wish to cover or disenroll.**
- **Type or print clearly in black ink.** Inaccurate, incomplete, or illegible information may delay coverage.

Are you making changes to an existing account? ❑ **Yes** ❑ **No** *If no, go to Section 1.*

If yes, what changes? *(Check all that apply in the sections below.)*

Changes you can make anytime *Give date of event/change* _____

❑ Name change
❑ Address change
❑ Disenroll dependent(s) due to loss of eligibility (divorce, legal separation documented by a court order, dissolution of domestic partnership, death, or other loss of eligibility under PEBB rules). **You must submit this form no later than 60 days after the event.** If applicable, provide dependent's new address:

_____

Additional changes you can make during annual open enrollment *All changes become effective January 1 of the following year.*

Check the box(es) next to the change requested.

❑ Add dependent(s) ❑ Change medical plan ❑ Waive medical coverage
❑ Disenroll dependent(s) ❑ Change dental plan ❑ Enroll after waiving medical coverage

Additional changes you can make if a qualifying event occurs (special open enrollment)

The PEBB Program will only allow changes outside of an annual open enrollment when allowed under PEBB rules (see WACs 182-12-262, 182-08-198, and 182-12-128). **You must submit this form no later than 60 days after the event.** However, if adding a newborn or newly adopted child, and adding the child increases your premium, you must submit this form no later than 12 months after the birth or adoption. You must provide proof of the event that created the special open enrollment.

Check the box(es) next to the change requested, and indicate the event(s) below. *Give date of event* _____

❑ Add dependent(s) ❑ Change health plan ❑ Enroll after waiving medical coverage
❑ Disenroll dependent(s) ❑ Waive medical coverage ❑ Other—explain: _____

❑ New spouse, Washington State-registered domestic partner, or child added to family due to marriage, Washington State-registered domestic partnership, birth, adoption, court order, or medical support order.
❑ Child becoming eligible as an extended dependent through legal custody or legal guardianship. *Also complete* Extended Dependent Certification *form. Form available at* **www.pebb.hca.wa.gov**.
❑ Child becoming eligible as a dependent with a disability. *Also complete* Certification of Dependents With Disabilities *form. Form available at* **www.pebb.hca.wa.gov**.
❑ Employee or dependent losing other coverage under a group health plan or through health insurance, as defined by the Health Insurance Portability and Accountability Act (HIPAA).
❑ Employee or dependent having a change in employment status that affects the employee's or dependent's eligibility for the employer contribution toward group health coverage.
❑ Employee or a dependent becoming eligible or losing eligibility for premium assistance through Medicaid or a state Children's Health Insurance Program (CHIP).

The following events also allow a health plan change:

❑ Employee or dependent having a change in residence that affects health plan availability.
❑ Employee or dependent becomes entitled to Medicare, or enrolls in or disenrolls from a Medicare Part D plan.
❑ Employee or dependent's current health plan becoming unavailable because the employee or dependent is no longer eligible for a health savings account (HSA).

Are you or any eligible dependents enrolled in PEBB coverage under another account? ❑ **Yes** ❑ **No**

Section 1: Subscriber Information

Social security number	Last name	First name	Middle initial	Sex ❑ M ❑ F

Street address	Apt./unit number	City	State	ZIP Code
Mailing address (if different from above)	Apt./unit number	City	State	ZIP Code
County of residence	Date of birth (mm/dd/yyyy)	Work phone number ( )	Home phone number ( )	

Medical Coverage ❑ Enroll ❑ Waive: effective date _____ *If waiving, see Section 6.*

Dental Coverage ☒ Enroll (Dental may not be waived.)

Note: If you waive coverage, you cannot enroll your eligible dependents in medical.

Agency name	Agency/subagency	Insurance effective date	Hire date

Subscriber's last name	First name	Middle initial	Social security number

Section 2: Spouse or Qualified/Washington State-Registered Domestic Partner

List eligible family members you wish to cover or disenroll. Family members cannot be enrolled in two PEBB medical or dental accounts at the same time.
If adding a family member, you must provide proof of eligibility within PEBB's enrollment timelines or the family member will not be enrolled.

Relationship to subscriber

If adding a Washington State-registered domestic partner, please attach a completed *Declaration of Tax Status* form.

❑ Spouse: date of marriage _____ ❑ Domestic partner: date qualified or registered _____

Social security number	Last name	First name	Middle initial	Sex ❑ M ❑ F

Street address (if different from subscriber)	Apt./unit number	City	State	ZIP Code

Date of birth (mm/dd/yyyy)	

Medical Coverage ❑ Cover ❑ Disenroll from medical: reason_____

Dental Coverage ❑ Cover ❑ Disenroll from dental: reason _____

Section 3: Family Member Information (such as a child) *Use additional forms for more members.*

List eligible family members you wish to cover or disenroll. Family members cannot be enrolled in two PEBB medical or dental accounts at the same time.
If adding a family member, you must provide proof of eligibility within PEBB's enrollment timelines or the family member will not be enrolled.
If adding a child of your qualified/Washington State-registered domestic partner, also attach a Declaration of Tax Status *form. Also attach appropriate certification form(s) if enrolling a dependent with a disability age 26 or older, or an extended dependent.*

A

Relationship to subscriber	Disabled? ❑ Yes ❑ No *(Check only if age 26 or older.)*	Sex ❑ M ❑ F	Social security number

Last name	First name	Middle initial	Date of birth (mm/dd/yyyy)

Street address (if different from subscriber)	Apt./unit number	City	State	ZIP Code

Medical Coverage ❑ Cover ❑ Disenroll from medical: reason_____

Dental Coverage ❑ Cover ❑ Disenroll from dental: reason _____

B

Relationship to subscriber	Disabled? ❑ Yes ❑ No *(Check only if age 26 or older.)*	Sex ❑ M ❑ F	Social security number

Last name	First name	Middle initial	Date of birth (mm/dd/yyyy)

Street address (if different from subscriber)	Apt./unit number	City	State	ZIP Code

Medical Coverage ❑ Cover ❑ Disenroll from medical: reason_____

Dental Coverage ❑ Cover ❑ Disenroll from dental: reason _____

C

Relationship to subscriber	Disabled? ❑ Yes ❑ No *(Check only if age 26 or older.)*	Sex ❑ M ❑ F	Social security number

Last name	First name	Middle initial	Date of birth (mm/dd/yyyy)

Street address (if different from subscriber)	Apt./unit number	City	State	ZIP Code

Medical Coverage ❑ Cover ❑ Disenroll from medical: reason_____

Dental Coverage ❑ Cover ❑ Disenroll from dental: reason _____

(continued)

2012 Employee Enrollment/Change *(continued)*

Subscriber's last name	First name	Middle initial	Social security number

Section 4: Medical Plan Selection *Check only one.*

Contact plans for benefits information; their contact information is at the end of this form.

Group Health Cooperative

- ❑ Group Health Classic
- ❑ Group Health Consumer-Directed Health Plan
- ❑ Group Health Value

Kaiser Foundation Health Plan of the Northwest

- ❑ Kaiser Permanente Classic
- ❑ Kaiser Permanente Consumer-Directed Health Plan

Uniform Medical Plan, administered by Regence BlueShield of Washington

- ❑ UMP Classic
- ❑ UMP Consumer-Directed Health Plan

Section 5: Dental Plan Selection *Check only one.*

Contact plans for benefits information; their contact information is at the end of this form.

Preferred Provider Organization

- ❑ Uniform Dental Plan, administered by Washington Dental Service (Group #3000), *(may receive services from any provider)*

Managed-Care Plans

- ❑ DeltaCare, administered by Washington Dental Service (Group #3100)
  Dentist name or clinic code _____
  (must receive services from a DeltaCare provider)
- ❑ Willamette Dental of Washington, Inc.
  Clinic location _____
  (must receive services from a Willamette Dental Group provider)

Section 6: Signature *Required*

By signing this form, I declare that the information I have provided is true, complete, and correct. If it isn't, or if I do not update this information within the timelines in PEBB rules, to the extent permitted by federal and state law, I must repay any claims paid by my health plan(s) or premiums paid on my behalf. My family members and I may also lose PEBB benefits as of the last day of the month we were eligible. To the extent permitted by law, PEBB or my employer may retroactively terminate coverage for me and my dependents if I intentionally misrepresent eligibility, or do not fully pay premiums when due. In addition, I understand that knowingly providing false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company is a crime, and can result in imprisonment, fines, denial of PEBB benefits, and loss of my job.

If adding a domestic partner to my account, I declare that my partner and I have registered through the Washington Secretary of State's Office.

Enrollment is not complete until verification of the family member's eligibility is successful. I understand that if I'm applying to add a dependent to my PEBB coverage, I must provide copies of documents that verify the dependent's eligibility within PEBB's enrollment timelines in WAC 182-12-262, or the dependent will not be enrolled.

If I waive medical, I understand I can enroll during the annual open enrollment period or within **60 days** of a special open enrollment event as defined in PEBB rules. If I waive medical for myself, I cannot enroll my eligible family members in medical.

I allow my employer to deduct money from my earnings to pay for the insurance coverage I requested.

If I am enrolling in a consumer-directed health plan, with a health savings account (HSA), I must meet HSA eligibility conditions. I understand that my employer will contribute to an HSA on my behalf based on the information I have provided, and that there are limits to these contributions and my HSA contributions (if any) under federal tax law.

This form replaces all *Employee Enrollment/Change* forms previously submitted to PEBB.

HCA's Privacy Notice: We will keep your information private as allowed by law. To receive our Privacy Notice, call 360-923-2822 (effective January 1, 2012, call 360-725-0442) or go to **www.hca.wa.gov.**

Subscriber's signature _____ **Date** _____

Please sign and date this form. Return completed form to your personnel, payroll, or benefits office.

2012 PEBB MEDICAL CONTRACTORS

Group Health Cooperative, 320 Westlake Ave. N, Suite 100, Seattle, WA 98109-5233, **1-888-901-4636 or TTY 1-800-833-6388**
Kaiser Foundation Health Plan of the Northwest, 500 NE Multnomah St., Suite 100, Portland, OR 97232-2099, **1-800-813-2000 or TTY 1-800-735-2900**
Uniform Medical Plan, administered by Regence BlueShield of Washington, P.O. Box 91015, MS BU248, Seattle, WA 98111-9115, **1-888-849-3681 or TTY 711**

2012 PEBB DENTAL CONTRACTORS

DeltaCare, administered by Washington Dental Service, 9706 Fourth Avenue NE, Seattle, WA 98115-2157, **1-800-650-1583**
Uniform Dental Plan, administered by Washington Dental Service, 9706 Fourth Avenue NE, Seattle, WA 98115-2157, **1-800-537-3406**
Willamette Dental of Washington, Inc., 6950 NE Campus Way, Hillsboro, OR 97124-5611, **1-855-433-6825**